



Ridgefield Pediatric Associates, P.C.

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HIPPA Consent Form

I, _____ authorize Ridgefield Pediatric Associates, P.C. to discuss all my medical information (ex: office visits, lab results and physicals) from date of birth to the age of 22 years old.

Signature _____ Date _____

If you would like a date different from above please specify _____

If there is information you would like us **NOT** to discuss pertaining to medical health please specify below:
(ex: Pregnancy test, STD testing or mental health issues)

Feel free to discuss my medical information with:

Name _____ Relationship to Patient _____

Name _____ Relationship to Patient _____

I understand that Ridgefield Pediatrics Associates P.C., will adhere to the regulations as outlined by HIPPA and will follow the guidelines I have outlined above.

Signature _____ Date _____

I **DO NOT** give permission for Ridgefield Pediatric Associates, P.C., to discuss any of my medical information with anyone other than myself.

Signature _____ Date _____

Best contact # to reach you? _____